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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH

02024

2051

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>	
CITY OR TOWN <u>Rockville Md</u>		LENGTH OF STAY <u>4 Months</u>		CITY OR TOWN <u>Street Md</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Emma</u> (Middle) <u>S</u> (Last) <u>AKINS</u>				(Month) <u>Feb</u> (Day) <u>8</u> (Year) <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 1865</u>	9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>Mary Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>218-32-9579A</u>		17. INFORMANT & ADDRESS <u>William AKINS Bel Air Rd Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>Acute pulmonary edema, terminating</u>						<u>Sudden</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>decompensated cardio-vascular disease.</u>						<u>10 years</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21a. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 15</u> , 19 <u>47</u> , to <u>Feb. 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 6</u> , 19 <u>58</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson M.D.</u>		DATE THEREOF <u>Feb 11/58</u>		NAME OF CEMETERY OR CREMATORY <u>Clark's Chapel</u>		LOCATION (City, town, or county) (State) <u>Forest Hill, Md. Feb. 8, 1958</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb 11/58</u>		NAME OF CEMETERY OR CREMATORY <u>Clark's Chapel</u>		LOCATION (City, town, or county) (State) <u>Kalmia Hartford Md</u>	
24. REC'D BY REGISTRAR <u>FEB 13 '58</u>		REGISTRAR'S SIGNATURE <u>Albreach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster Belau</u>		ADDRESS	

CERTIFICATE

MADE ON BOARD

COAST

MARYLAND

DATE

RECEIVED

DATE

TIME

PLACE

NAME

AGE

SEX

HEIGHT

WEIGHT

HAIR

EYES

TEETH

SCARS

MARKS

PIERCINGS

OTHER

REMARKS

SIGNATURE

OFFICIAL

NOTARY

STATE

COUNTY

TOWNSHIP

PARISH

WARD

PRESTON

CHURCH

SCHOOL

CLUB

ASSOCIATION

ORGANIZATION

INSTITUTION

ESTABLISHMENT

CONCERN

INTEREST

RELATIONSHIP

CONNECTION

LINK

BUREAU V. 2

FEB 13 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2052 CERTIFICATE OF DEATH

Reg. Dist. No.

02025

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Black Horse</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Black Horse</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>William Anderson Bahel</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov-1922</u>	9. AGE (In years last birthday) <u>35</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Not Known</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-09-534</u>		17. INFORMANT <u>Levi B Palmer</u> Address <u>White Hall Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arterio-sclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 1</u> , 19 <u>58</u> , to <u>Feb 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 7</u> , 19 <u>58</u> , and that death occurred at <u>4:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. France</u> M.D.				ADDRESS (Street, city or town, state) <u>Parkton, Md</u>			
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>				DATE SIGNED <u>2/8/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 10-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tarrettsville</u>		22d. LOCATION (City, town, or county) (State) <u>Tarrettsville, Hartford - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion Kurtz</u>				ADDRESS <u>Donettsville</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 13 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the general director, TO FUNERAL DIRECTOR: Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
17. NAME OF PHYSICIAN		18. ADDRESS OF PHYSICIAN		19. NAME OF REGISTRAR		20. ADDRESS OF REGISTRAR		21. NAME OF WITNESSES		22. ADDRESS OF WITNESSES		23. NAME OF FUNERAL HOME		24. ADDRESS OF FUNERAL HOME	
25. NAME OF BURIAL PLACE		26. ADDRESS OF BURIAL PLACE		27. NAME OF CEMETERY		28. ADDRESS OF CEMETERY		29. NAME OF INTERMENT		30. ADDRESS OF INTERMENT		31. NAME OF CREMATOR		32. ADDRESS OF CREMATOR	
33. NAME OF NEXT OF KIN		34. ADDRESS OF NEXT OF KIN		35. NAME OF SURVIVORS		36. ADDRESS OF SURVIVORS		37. NAME OF ESTATE		38. ADDRESS OF ESTATE		39. NAME OF LEGAL REPRESENTATIVE		40. ADDRESS OF LEGAL REPRESENTATIVE	
41. NAME OF FUNERAL HOME		42. ADDRESS OF FUNERAL HOME		43. NAME OF BURIAL PLACE		44. ADDRESS OF BURIAL PLACE		45. NAME OF CEMETERY		46. ADDRESS OF CEMETERY		47. NAME OF INTERMENT		48. ADDRESS OF INTERMENT	
49. NAME OF CREMATOR		50. ADDRESS OF CREMATOR		51. NAME OF NEXT OF KIN		52. ADDRESS OF NEXT OF KIN		53. NAME OF SURVIVORS		54. ADDRESS OF SURVIVORS		55. NAME OF ESTATE		56. ADDRESS OF ESTATE	
57. NAME OF LEGAL REPRESENTATIVE		58. ADDRESS OF LEGAL REPRESENTATIVE		59. NAME OF FUNERAL HOME		60. ADDRESS OF FUNERAL HOME		61. NAME OF BURIAL PLACE		62. ADDRESS OF BURIAL PLACE		63. NAME OF CEMETERY		64. ADDRESS OF CEMETERY	
65. NAME OF INTERMENT		66. ADDRESS OF INTERMENT		67. NAME OF CREMATOR		68. ADDRESS OF CREMATOR		69. NAME OF NEXT OF KIN		70. ADDRESS OF NEXT OF KIN		71. NAME OF SURVIVORS		72. ADDRESS OF SURVIVORS	
73. NAME OF ESTATE		74. ADDRESS OF ESTATE		75. NAME OF LEGAL REPRESENTATIVE		76. ADDRESS OF LEGAL REPRESENTATIVE		77. NAME OF FUNERAL HOME		78. ADDRESS OF FUNERAL HOME		79. NAME OF BURIAL PLACE		80. ADDRESS OF BURIAL PLACE	
81. NAME OF CEMETERY		82. ADDRESS OF CEMETERY		83. NAME OF INTERMENT		84. ADDRESS OF INTERMENT		85. NAME OF CREMATOR		86. ADDRESS OF CREMATOR		87. NAME OF NEXT OF KIN		88. ADDRESS OF NEXT OF KIN	
89. NAME OF SURVIVORS		90. ADDRESS OF SURVIVORS		91. NAME OF ESTATE		92. ADDRESS OF ESTATE		93. NAME OF LEGAL REPRESENTATIVE		94. ADDRESS OF LEGAL REPRESENTATIVE		95. NAME OF FUNERAL HOME		96. ADDRESS OF FUNERAL HOME	
97. NAME OF BURIAL PLACE		98. ADDRESS OF BURIAL PLACE		99. NAME OF CEMETERY		100. ADDRESS OF CEMETERY		101. NAME OF INTERMENT		102. ADDRESS OF INTERMENT		103. NAME OF CREMATOR		104. ADDRESS OF CREMATOR	

BUREAU V. B.

FEB 13 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02026

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrods Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harrods Grace</u>	
c. LENGTH OF STAY IN 1b <u>LIFE</u>		d. STREET ADDRESS <u>627 Fountain St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>627 Fountain St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Howard</u> First <u>Andrew Bauer</u> Middle <u>Andrew</u> Last		4. DATE OF DEATH <u>February 26 1958</u> Month <u>February</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 27, 1894</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF FUNDED YEAR <u>11</u> Months <u>29</u> Days <u>29</u> Hours <u>Min.</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>F. H. I. MAINTAINANCE THERMAN</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11c. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>JOHN W. BAUER</u>		14. MOTHER'S MAIDEN NAME <u>MARY K. FRENCH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WORLDWARI</u>		16. SOCIAL SECURITY NO. <u>215-12-1875</u>	
17. INFORMANT <u>REBECCA M. BAUER</u>		Address <u>627 FOUNTAIN ST HARRODS GRACE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G.S.W. Cerebrum</u> <u>976x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>976x</u> DUE TO (c) <u>976x</u>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>976x</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot Self</u>	
20c. TIME OF INJURY Month, Day, Year <u>2-26 1958</u> Hour <u>10</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Harrods Grace</u> (County) <u>Hartford</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald P. Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md.</u> DATE SIGNED <u>2-27-58</u>	
EXAMINER'S NAME (Type) <u>Gerald P. Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAR 1, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>	22d. LOCATION (City, town, or county) <u>HARRODS GRACE MD.</u> (State) <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell, 1233 W. 1st St. Md.</u>		24a. REC'D BY REGISTRAR <u>Mar 3 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Quesada</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 3 1958

RECEIVED

2053 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)		c. LENGTH OF STAY IN 1b X Aberdeen (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. 2		d. STREET ADDRESS R.D. 2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Roland Middle Milfred Last Bodt		4. DATE OF DEATH Month February Day 24 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Jan. 1888
9. AGE (In years last birthday) yrs. 70		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm-Self Emp.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew P. Bodt		14. MOTHER'S MAIDEN NAME Cora L. Greenland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-03-1548	
17. INFORMANT Anella Bodt, R.D. 2, Aberdeen, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C-V disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Unk 4-5 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 56 , to Feb 24 , 19 58 , that I last saw the deceased alive on Jan 30 , 19 58 , and that death occurred at 9 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Darlington, Md. DATE SIGNED 2/25/58			
ACTUAL SIGNATURE Dudley Phillips M.D.		DATE SIGNED 2/25/58	
PHYSICIAN'S NAME (Type) Dudley Phillips M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/27/58	22c. NAME OF CEMETERY OR CREMATORY Churchville Presbyterian	22d. LOCATION (City, town, or county) (State) Churchville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John H. Larring		ADDRESS Aberdeen, Md.	24a. REC'D BY REGISTRAR DATE FEB 27 '58
		24b. REGISTRAR'S SIGNATURE Aberdeen	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased: [illegible] Sex: [illegible] Age: [illegible]

Place of Birth: [illegible] (State) [illegible]

Date of Birth: [illegible]

Place of Death: [illegible] [illegible]

Date of Death: [illegible]

Cause of Death: [illegible]

Signature of Physician: [illegible]

Signature of Registrar: [illegible]

BUREAU V. E.

FEB 27 1958

RECEIVED

Dr. J. H. Phillips

Dr. J. H. Phillips

Baltimore, Md.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, it must be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Item 9, Film G227, 4/8/58										
2451										
CERTIFICATE OF DEATH										
Reg. Dist. No. 02028 180										
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon			c. LENGTH OF STAY IN 1b 26 yrs.,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Abingdon					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Keziah Middle Braxton Last Braxton					4. DATE OF DEATH Month Feb. Day 19 Year 19 58					
5. SEX female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 1, 1870		9. AGE (In years last birthday) 77 87 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Benjamin Fountain					14. MOTHER'S MAIDEN NAME Charlotte Osborne					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Thomas Braxton, Abingdon, Maryland						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular disease DUE TO (c) Hypertensive Cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19					20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/12 , 19 58 , to 2/19 , 19 58 , that I last saw the deceased alive on 2/19 , 19 58 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 569 Revolution St., Havre de Grace, Md. DATE SIGNED 2/22/58 ACTUAL SIGNATURE George T. Stansbury M.D. PHYSICIAN'S NAME (Type) George T. Stansbury 569 Revolution St., Havre de Grace, Md.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 23, 1958		22c. NAME OF CEMETERY OR CREMATORY John Wesley			22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McEwen Jr. ADDRESS Abingdon, Md.,					24a. REC'D. BY REGISTRAR DATE Feb 23 1958		24b. REGISTRAR'S SIGNATURE W. J. ...			

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		DATE OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		CITY [Illegible]	
COUNTY [Illegible]		STATE [Illegible]	
AGE [Illegible]		SEX [Illegible]	
MARRIED [Illegible]		OCCUPATION [Illegible]	
EDUCATION [Illegible]		RELIGION [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF DEATH REGISTRAR [Illegible]	
DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]	

BUREAU V. S.
FEB 26 1938

RECEIVED

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02029

2055 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITE FORD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITE FORD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle CARRIE Last BULL		4. DATE OF DEATH Month 2 Day 27 Year 1958	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-3-1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ABRAHAM H. HARE		14. MOTHER'S MAIDEN NAME MARY LAWSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-07-1100	
17. INFORMANT Mrs. Walter B. Morris, Whiteford, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gen. Art. Sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH Immediate	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 1957 to Feb. 27, 1958 , that I last saw the deceased alive on Feb. 20, 1958 , and that death occurred at 4 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joshua A. Hunt M.D.		ADDRESS (Street, city or town, state) Delta, Pa.	
PHYSICIAN'S NAME (Type) Joshua A. Hunt, M.D.		DATE SIGNED 2/28/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-2-58	
22c. NAME OF CEMETERY OR CREMATORY MIDDLETOWN CEM.		22d. LOCATION (City, town, or county) (State) MIDDLETOWN, BALTO. CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. Plummer		ADDRESS Stewartstown Pa.	
24a. REC'D BY REGISTRAR DATE MAR 3 '58		24b. REGISTRAR'S SIGNATURE Delmar	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02030

2035

1. PLACE OF DEATH o. COUNTY <u>Harford County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrods Grace</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X. Sel Cur</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>Box 89, Rt. #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Samuel</u> First <u>Fernandes</u> Middle <u>Collins</u> Last			4. DATE OF DEATH <u>February 23</u> Month <u>23</u> Day <u>1958</u> Year				
5. SEX <u>m</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-20-1892</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cement Finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel F. Collins Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Lucinda Hutton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>108-14-9638</u>		17. INFORMANT <u>Daniel R. Collins - Nephew</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> DUE TO <u>Pulmonary Embolus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Deep Saphenous Phlebotrombosis</u> DUE TO <u>Prothrombotic</u> (c) <u>Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>50213</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-20-58</u> , to <u>2-23-58</u> , that I last saw the deceased alive on <u>2-21-58</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter P. Rodman, M.D.</u>				ADDRESS (Street, city or town, state) <u>8 Law St. Aberdeen, Md.</u>		DATE SIGNED <u>2-23-58</u>	
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-28-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clarks Chapel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Kalmar, Harford Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Atchis J. Bullock - Harrods Grace, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>Feb 26 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>			

FEB 26 1958

RECEIVED
FEB 26 1953

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02031

2436

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harrods Creek</i>	c. LENGTH OF STAY IN lb <i>6 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>24 Harrods Creek</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Sumner & Revolution Sta</i>		d. STREET ADDRESS <i>218 Washington St</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Alice Elizabeth Diamond</i>	4. DATE OF DEATH <i>February 5</i>	Year <i>1938</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> - NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-4-94</i>
9. AGE (In years last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mathematician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Admission Proving Dept.</i>	
11. BIRTHPLACE (State or foreign country) <i>Indiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Adolph Diamond</i>		14. MOTHER'S MAIDEN NAME <i>Hemiatta Pottlizer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Mr Warren Bush</i>		Address <i>26 Elm St, W. Va.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>420.1</i> (c) <i>420.1</i> DUE TO cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>420.1</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Israel C Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Be/4ir	
EXAMINER'S NAME (Type) <i>Israel C Palmer M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Ma	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>2-8-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Crementation</i>	22b. DATE THEREOF <i>2/10/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Unknown</i>	22d. LOCATION (City, town, or county) (State) <i>Parkersburg W. Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Conington Rm. Harrods Creek, Md.</i>		24a. REC'D BY REGISTRAR <i>Feb 13 '58</i>	
24b. REGISTRAR'S SIGNATURE <i>Paul</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text and stamps, including "RECEIVED" and "BUREAU V. 2" visible in the background.]

1. NAME OF DECEASED
2. SEX
3. AGE
4. OCCUPATION
5. PLACE OF BIRTH
6. DATE OF DEATH
7. TIME OF DEATH
8. PLACE OF DEATH
9. CAUSE OF DEATH
10. MANNER OF DEATH

BUREAU V. 2

FEB 13 1933

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02032

2037 CERTIFICATE OF DEATH

Item 1 FilmG226 3-7-58 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>32</u> TOWN <u>Bel Air</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 PHARMACY</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>PEARLINE</u> <u>PEARLINE COHEN FORMAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 23</u> 19 <u>58</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>CO</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1912</u>	9. AGE last birthday <u>46</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Wm Cohen</u>				14. MOTHER'S MAIDEN NAME <u>MARY BOND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS <u>DAVID BROWN</u> <u>FALLSTON MD</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
170X IMMEDIATE CAUSE (A) <u>CARCINOMATOSIS</u>						<u>6 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CARCINOMA OF BREAST</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>JULY</u> , 19 <u>53</u> , to <u>FEB. 23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>FEB 22</u> , 19 <u>58</u> , and that death occurred at <u>7:20</u> A.M., from the causes and on the date stated above. SIGNATURE <u>Paul S. Stonecipher Jr.</u> ADDRESS (Street, city, town, state) <u>M.D. 115 FULFORD AVE., BELAIR MD.</u> DATE SIGNED <u>2/23/58</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>FEB 26/58</u>		NAME OF CEMETERY OR CREMATORY <u>TABERNACLE</u>		LOCATION (City, town, or county) (State) <u>HARTFORD CO MD</u> <u>Benson</u>	
24. REC'D BY REGISTRAR DATE <u>FEB 28 '58</u>		REGISTRAR'S SIGNATURE <u>W. Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Bel Air</u> ADDRESS			

CERTIFICATE OF DEATH

REG. GEN. NO.

AT WHAT RESIDENCE DECEASED BY DECLARED

DATE

TIME

PLACE

CAUSE OF DEATH

1. Name of deceased: *John Doe*
 2. Sex: *Male*
 3. Age: *45*
 4. Race: *White*
 5. Marital status: *Married*
 6. Occupation: *Teacher*
 7. Usual residence: *123 Main St, Baltimore, Md.*
 8. Date of death: *Feb 25, 1953*
 9. Time of death: *10:30 AM*
 10. Place of death: *Home*
 11. Cause of death: *Myocardial infarction*
 12. Immediate cause: *Coronary artery disease*
 13. Underlying cause: *Arteriosclerosis*
 14. Contributing cause: *Smoking, high blood pressure*
 15. Manner of death: *Natural*
 16. Signature of physician: *Dr. J. K. Smith*
 17. Signature of registrar: *John Doe*
 18. Signature of informant: *John Doe*
 19. Signature of medical examiner: *Dr. J. K. Smith*
 20. Signature of coroner: *John Doe*

BUREAU V. 2

FEB 28 1953

RECEIVED

RECORDED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02033

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

2038			
1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford de Grace</u>	c. LENGTH OF STAY IN 1b <u>—</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>S. Main</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Jones</u> Last <u>Founds</u>		4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 3, 1870</u>
		9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Day</u>	11. BIRTHPLACE (State or foreign country) <u>Md Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>George rounds</u>		14. MOTHER'S MAIDEN NAME <u>Annie Campbell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Robert Campbell, Port Deposit, Md. RD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>900.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stairs</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>5</u> a.m. <u>2-7</u> 19 <u>58</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Port Deposit Cecil Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>B. A. Arndt</u> DATE SIGNED <u>2-8-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-10-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>nopewell</u>	22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

NAME OF DECEASED: Robert Campbell
AGE: 45 SEX: M
DATE OF DEATH: Feb 11 1958
PLACE OF DEATH: Home
RESIDENT OF: State of Maryland
OCCUPATION: None
REPORT BY: Dr. Robert Campbell
CAUSE OF DEATH: Heart Disease
MANNER OF DEATH: Natural
SIGNATURE OF EXAMINER: Robert Campbell
TITLE: Medical Examiner

DECEASED'S SIGNATURE

RECEIVED
FEB 11 1958
BUREAU V. 2

2039
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford de Grace</u>				c. LENGTH OF STAY IN 1b <u>11 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Mem. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BABY BOY</u> First Middle Last <u>Goodson</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-3-58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) yrs. <u>13</u> Months <u>25</u> Days <u>13</u> Hours <u>25</u> Min.	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Lowell Goodson</u>				14. MOTHER'S MAIDEN NAME <u>Marilyn Louise Matthews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANOXIA (CEREBRAL)</u> <u>754.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CONGENITAL HEART DEFORMITY</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>11 HRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>2:3</u> , 19 <u>58</u> , to <u>2:4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2:4</u> , 19 <u>58</u> , and that death occurred at <u>7:20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>RB/Perman</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. <u>REMOVAL</u> CREMATION, (Specify)		22b. DATE THEREOF <u>2-4-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSPITAL</u>		22d. LOCATION (City, town, or county) <u>Harford de Grace Md</u> , (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry R. Cully</u> ADDRESS <u>Administrator</u>				24a. RECEIVED BY REGISTRAR <u>DATE FEB 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred J. Smith</u>	

2071182XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2056 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY HARFORD

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)RURAL-BEL AIRLENGTH OF STAY
(in this place)2HOSPITAL OR
INSTITUTION OR
STREET ADDRESSHARFORD COUNTY ALMHOUSE

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLANDCOUNTY HARFORD

CITY (If outside corporate limits, write RURAL and give nearest town)

24 HAVRE DE GRACESTREET
ADDRESS

(If rural give location)

3. NAME OF
DECEASED
(Type or Print)

(First)

(Middle)

(Last)

JAMESK.GRAY4. DATE
OF
DEATH

(Month)

(Day)

(Year)

FEBRUARY 131958

5. SEX

male6. COLOR OR
RACEWHITE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)WIDOWED

8. DATE OF BIRTH

11-24-78

9. AGE last birthday

79

yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)RETIRED-CARPENTER10b. KIND OF BUSINESS
OR INDUSTRY7

11. BIRTHPLACE (State or foreign country)

VIRGINIA12. CITIZEN OF WHAT
COUNTRY?UNITED STATES

13. FATHER'S NAME

RICHARD GRAY

14. MOTHER'S MAIDEN NAME

ANN PORTER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

NO

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT & ADDRESS

FROM RECORDS ON ADMISSIONCLARK FITZPATRICK, SUPT. ALMHOUSE

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE (A) CORONARY OCCLUSION

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B) CHRONIC CARDIO-VASCULAR DISEASE

GIVING RISE TO THE ABOVE CAUSE DUE TO

STATING UNDERLYING CAUSE LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.CHRONIC OSTEO-ARTHRITIS

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN
ONSET AND DEATHSUDDEN

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21a. INJURY OCCURRED

While ☐ Not while ☐

M. of work of work

21i. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/1/53, 19 53, to 2/13, 19 58 that I last saw the deceased
alive on FEB. 10, 19 58, and that death occurred at 8 P.M., from the causes and on the date stated above.

SIGNATURE

Willard P. Hudson M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)Burial

DATE THEREOF

2/16/58

NAME OF CEMETERY OR CREMATORY

Bakers CemeteryFOREST HILLMARYLAND

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE FEB 18 '58John G. Tarring Aberdeen, Md.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M.

CERTIFICATE OF DEATH

Dec 10 1958

1. NAME OF DECEASED (Print or Write)

2. SEX (Print or Write)

3. DATE OF BIRTH (Print or Write)

4. PLACE OF BIRTH (Print or Write)

5. OCCUPATION (Print or Write)

6. MARITAL STATUS (Print or Write)

7. CAUSE OF DEATH (Print or Write)

8. PLACE OF DEATH (Print or Write)

9. SIGNATURE OF DECEASED (Print or Write)

10. SIGNATURE OF WITNESSES (Print or Write)

11. SIGNATURE OF PHYSICIAN (Print or Write)

12. SIGNATURE OF CORONER (Print or Write)

13. SIGNATURE OF JURY (Print or Write)

14. SIGNATURE OF JUDGE (Print or Write)

15. SIGNATURE OF CLERK (Print or Write)

16. SIGNATURE OF NOTARY (Print or Write)

17. SIGNATURE OF REGISTRAR (Print or Write)

18. SIGNATURE OF ARCHIVIST (Print or Write)

19. SIGNATURE OF ASSISTANT (Print or Write)

20. SIGNATURE OF CLERK (Print or Write)

21. SIGNATURE OF NOTARY (Print or Write)

22. SIGNATURE OF REGISTRAR (Print or Write)

23. SIGNATURE OF ARCHIVIST (Print or Write)

24. SIGNATURE OF ASSISTANT (Print or Write)

25. SIGNATURE OF CLERK (Print or Write)

26. SIGNATURE OF NOTARY (Print or Write)

27. SIGNATURE OF REGISTRAR (Print or Write)

28. SIGNATURE OF ARCHIVIST (Print or Write)

29. SIGNATURE OF ASSISTANT (Print or Write)

30. SIGNATURE OF CLERK (Print or Write)

31. SIGNATURE OF NOTARY (Print or Write)

32. SIGNATURE OF REGISTRAR (Print or Write)

33. SIGNATURE OF ARCHIVIST (Print or Write)

34. SIGNATURE OF ASSISTANT (Print or Write)

35. SIGNATURE OF CLERK (Print or Write)

36. SIGNATURE OF NOTARY (Print or Write)

37. SIGNATURE OF REGISTRAR (Print or Write)

38. SIGNATURE OF ARCHIVIST (Print or Write)

39. SIGNATURE OF ASSISTANT (Print or Write)

40. SIGNATURE OF CLERK (Print or Write)

41. SIGNATURE OF NOTARY (Print or Write)

42. SIGNATURE OF REGISTRAR (Print or Write)

43. SIGNATURE OF ARCHIVIST (Print or Write)

BUREAU V. 11

EB 18 1958

RECEIVED

John S. Tetter, Asst. Secy.

2/10/58

Public Health

EXHIBIT 100

1. NAME OF DECEASED (Print or Write)
2. SEX (Print or Write)
3. DATE OF BIRTH (Print or Write)
4. PLACE OF BIRTH (Print or Write)
5. OCCUPATION (Print or Write)
6. MARITAL STATUS (Print or Write)
7. CAUSE OF DEATH (Print or Write)
8. PLACE OF DEATH (Print or Write)
9. SIGNATURE OF DECEASED (Print or Write)
10. SIGNATURE OF WITNESSES (Print or Write)
11. SIGNATURE OF PHYSICIAN (Print or Write)
12. SIGNATURE OF CORONER (Print or Write)
13. SIGNATURE OF JURY (Print or Write)
14. SIGNATURE OF JUDGE (Print or Write)
15. SIGNATURE OF CLERK (Print or Write)
16. SIGNATURE OF NOTARY (Print or Write)
17. SIGNATURE OF REGISTRAR (Print or Write)
18. SIGNATURE OF ARCHIVIST (Print or Write)
19. SIGNATURE OF ASSISTANT (Print or Write)
20. SIGNATURE OF CLERK (Print or Write)
21. SIGNATURE OF NOTARY (Print or Write)
22. SIGNATURE OF REGISTRAR (Print or Write)
23. SIGNATURE OF ARCHIVIST (Print or Write)
24. SIGNATURE OF ASSISTANT (Print or Write)
25. SIGNATURE OF CLERK (Print or Write)
26. SIGNATURE OF NOTARY (Print or Write)
27. SIGNATURE OF REGISTRAR (Print or Write)
28. SIGNATURE OF ARCHIVIST (Print or Write)
29. SIGNATURE OF ASSISTANT (Print or Write)
30. SIGNATURE OF CLERK (Print or Write)
31. SIGNATURE OF NOTARY (Print or Write)
32. SIGNATURE OF REGISTRAR (Print or Write)
33. SIGNATURE OF ARCHIVIST (Print or Write)
34. SIGNATURE OF ASSISTANT (Print or Write)
35. SIGNATURE OF CLERK (Print or Write)
36. SIGNATURE OF NOTARY (Print or Write)
37. SIGNATURE OF REGISTRAR (Print or Write)
38. SIGNATURE OF ARCHIVIST (Print or Write)
39. SIGNATURE OF ASSISTANT (Print or Write)
40. SIGNATURE OF CLERK (Print or Write)
41. SIGNATURE OF NOTARY (Print or Write)
42. SIGNATURE OF REGISTRAR (Print or Write)
43. SIGNATURE OF ARCHIVIST (Print or Write)

2057 CERTIFICATE OF DEATH

02036

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston - Rural				c. LENGTH OF STAY IN 1b 20 Yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston - Rural X				d. STREET ADDRESS Hess Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle HALL Last HALL				4. DATE OF DEATH Month February Day 25 Year 1958			
5. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min. 85	11. IF UNDER 24 HRS. Months 85 Days 85 Hours 85 Min. 85	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Barriergard Davis			
14. MOTHER'S MAIDEN NAME Mary -----				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. -----				17. INFORMANT CHARLES HALL Address Fallston Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Hypertensive Heart Disease 15 years DUE TO (c) 1 week							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 29, 1958 , to February 25, 1958 , that I last saw the deceased alive on February 25, 1958 , and that death occurred at 10 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE S. James Thomison, Jr., M.D.							
PHYSICIAN'S NAME (Type) S. JAMES THOMISON, Jr., M. D., Jarrettsville, Maryland 2/26/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb. 28, 1958			
22c. NAME OF CEMETERY OR CREMATORY West Liberty				22d. LOCATION (City, town, or county) (State) Upper Cross Roads, Harford Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Martin Skutz Jarrettsville Md				24a. REC'D BY REGISTRAR DATE MAR 4 '58			
24b. REGISTRAR'S SIGNATURE Alb...							

TO HOSPITAL: The attending physician: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1995

450151

2025 RELEASE UNDER E.O. 14176

BUREAU V. S.

MAR 7 1958

RECEIVED

2058 CERTIFICATE OF DEATH

02037

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PLYESVILLE		c. LENGTH OF STAY IN 1b 76 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NEWTON E. HEAPS		4. DATE OF DEATH Month Day Year FEB: 15, 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 5, 1882
9. AGE (In years and birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM OWNER		10b. KIND OF BUSINESS OR INDUSTRY DAIRY	
11. BIRTHPLACE (State or foreign country) PLYESVILLE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS W. HEAPS		14. MOTHER'S MAIDEN NAME RACHEL SCARBOROUGH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address MRS. DORA W. HEAPS, PLYESVILLE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 Bronchopneumonia, bilat. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of jaw and neck- DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT. 1958 to 15 Feb. 1958 , that I last saw the deceased alive on 15 Feb. 1958 , and that death occurred at 5:45 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Warrettsville, Md. DATE SIGNED 15 Feb 1958			
ACTUAL SIGNATURE Thos. A.E. Moseley Jr. M.D.			
PHYSICIAN'S NAME (Type) THOMAS A.E. MOSELEY JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	2-21-58	HIGHLAND	STREET, MD.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John H. Harbison, Delta, Pa.		24a. REC'D BY REGISTRAR DATE FEB 24 1958	24b. REGISTRAR'S SIGNATURE W. H. ...

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 24 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. File pages 1 and 2 with the State Board of Health.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02038

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hta. co. A home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Jesserson</u> Middle <u>T</u> Last		4. DATE OF DEATH <u>February 18</u> 19 <u>58</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 27 - 1898</u>
9. AGE (in years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barber</u>	
11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-20-6515</u>	
17. INFORMANT <u>Clark Fitzpatrick</u> Address <u>Bel Air Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-18-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 19 - 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Harford Co - Home</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Rural Harford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Fisher</u> ADDRESS <u>Bel Air Md</u>		24a. REC'D BY REGISTRAR <u>DeLoach</u>	
DATE <u>FEB 20 1958</u>		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT



BUREAU V. E.

FEB 20 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2041

CERTIFICATE OF DEATH

02039

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford - Grace</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>	
3. NAME OF DECEASED (Type or print) <u>Coleman Amos Keithley</u>		4. DATE OF DEATH Month <u>2</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/10/1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
13. FATHER'S NAME <u>James Keithley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Culver.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None.</u>	
17. INFORMANT <u>Lucy C. Keithley</u>		Address <u>Edgewood, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia + Paratuberculosis (prob. spec.)</u> 584X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ascending cholangitis</u> DUE TO (c) <u>Common duct stone, cholangitis, obstruction</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 5</u> , 19 <u>58</u> , to <u>Feb 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 20</u> , 19 <u>58</u> , and that death occurred at <u>6:25 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm K. Brendle</u> M.D.		ADDRESS (Street, city or town, state) <u>610 S. Union Ave</u> DATE SIGNED <u>2/20/58</u>	
PHYSICIAN'S NAME (Type) <u>Wm. K. Brendle</u> M.D.		Havre de Grace, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/23/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Garrison Aberdeen Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 26 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Hearn</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1888		NEW YORK		NEW YORK		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
1234 E. BALTIMORE ST.		DRUGGIST		HEART DISEASE		NATURAL		FEB 26 1938		BALTIMORE		BALTIMORE		BALTIMORE	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARRIED		SINGLE		WIDOW		DIVORCED	
JAMES H. HARRIS		MARY J. HARRIS		HIGH SCHOOL		METHODIST		YES		NO		NO		NO	
DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
FEB 15 1935		NEW YORK		NEW YORK		NEW YORK		FEB 26 1938		BALTIMORE		BALTIMORE		BALTIMORE	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S MARRIED		MOTHER'S MARRIED	
DRUGGIST		HOUSEWIFE		HIGH SCHOOL		HIGH SCHOOL		METHODIST		METHODIST		YES		YES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
FEB 26 1938		BALTIMORE		BALTIMORE		BALTIMORE		FEB 26 1938		BALTIMORE		BALTIMORE		BALTIMORE	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARRIED		SINGLE		WIDOW		DIVORCED	
JAMES H. HARRIS		MARY J. HARRIS		HIGH SCHOOL		METHODIST		YES		NO		NO		NO	

RECEIVED
FEB 26 1938
BUREAU V. S.

MEDICAL CERTIFICATION

RECEIVED
FEB 20 1958
BUREAU V. B.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

02041

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fallston, Rural</u>		LENGTH OF STAY (in this place) <u>6 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fallston, Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>Mountain Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Margaret A. Lewis</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 26, 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Dec. 19, 1880</u>		9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Wales</u>		12. CITIZEN OF WHAT COUNTRY? <u>Wales</u>	
13. FATHER'S NAME <u>JAMES HOWELLS</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>148-05-9723</u>		17. INFORMANT & ADDRESS <u>Mrs. Edith Loignon, Fallston, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
171X IMMEDIATE CAUSE (A) <u>INANITION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 Mos.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CARCINOMA OF CERVIX Uteri</u>						<u>14 Mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>8/16/54</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/8</u> , 19 <u>57</u> , to <u>2/26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/26</u> , 19 <u>58</u> , and that death occurred at <u>9:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Clifford F. Hudson</u>				ADDRESS (Street, city, town, state) <u>FORK, MD.</u>			
DATE SIGNED <u>2/26/58</u>				DATE SIGNED <u>2/26/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MAR 1, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Berlin Cemetery</u>		LOCATION (City, town, or county) (State) <u>Berlin, N. J.</u>	
24. REC'D BY REGISTRAR DATE <u>FEB 28 '58</u>		REGISTRAR'S SIGNATURE <u>Albeauch</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>		ADDRESS <u>Bel Air, md.</u>	

CERTIFICATE OF DEATH

Form No. 10-1-15

LOCAL DEPARTMENT OF HEALTH OR HOSPITAL

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

DATE OF DEPARTURE

PLACE OF DEPARTURE

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BUREAU V. 2

FEB 28 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02042

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as soon as possible, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY in lb <u>Like</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lee St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bessie Matthews</u>		4. DATE OF DEATH <u>February 13 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug 20 1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hartford Md</u>	
11. BIRTHPLACE (State or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Matthews</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-32-2753</u>	
17. INFORMANT <u>Mrs Lila Young</u> Address <u>4324 Willow Ave Baltimore 12 MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Be/Air; Md. DATE SIGNED <u>2-13-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J Foster</u> ADDRESS <u>Bel Air Md</u>		24a. REC'D BY REGISTRAR <u>FEB 18 58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
NEW YORK STATE EXAMINER'S CERTIFICATE OF DEATH

NEW YORK STATE
DEPARTMENT OF HEALTH



BUREAU V. 21

FEB 18 1958

RECEIVED

1. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2043

CERTIFICATE OF DEATH

02043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 118 Edmund Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Abbie Mae McKelvey		4. DATE OF DEATH February 22 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 October 1882
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Rhoades		14. MOTHER'S MAIDEN NAME Margaret Garris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ** **	
17. INFORMANT Eunice V. Castelow		Address 118 Edmund St. Aberdeen Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Diabetic Acidosis DUE TO (b) Diabetic Gangrene, Right Foot Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH 4 days 4 months 5 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 23 19 58 , to Feb. 22 19 58 that I last saw the deceased alive on Feb. 22 19 58 , and that death occurred at 11:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter P. Rodman M.D.		ADDRESS (Street, city or town, state) 8 Law Street DATE SIGNED 2-23-58	
PHYSICIAN'S NAME (Type) Peter P. Rodman M.D.		Aberdeen, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 2/24/58	22c. NAME OF CEMETERY OR CREMATORY Ligonier Valley Cem.	22d. LOCATION (City, town, or county) (State) Ligonier, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring		ADDRESS Aberdeen, Md.	
24a. REC'D BY REGISTRAR FEB 26 58		24b. REGISTRAR'S SIGNATURE W. H. ...	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Harford

Harford

Harford

Harford

Abertson

Abertson

115 Edward Street

115 Edward Street

Abertson

Abertson

Abertson

2 October 1882

Abertson

U.S.A.

Harford

Harford

Harford

Margaret Davis

Michael Rhoades

Harford

John V. Tassellow

John V. Tassellow

No

BUREAU V. S.

FEB 26 1933

RECEIVED

Abertson

Abertson

Abertson Valley Co. Harford

Abertson Valley Co. Harford

Abertson, Md.

John G. Tassellow

RECEIVED

1 2061 2061 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02045

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)		c. LENGTH OF STAY IN 1b X Aberdeen (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #1		d. STREET ADDRESS Route #1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carroll Middle Stewart Last Osborn		4. DATE OF DEATH Month February Day 18 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 March 1887
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months 18 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luther Stewart Osborn		14. MOTHER'S MAIDEN NAME Sarah Rebecca Wells	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-32-7548-A	
17. INFORMANT Mrs. Margaret Osborn		Address R.D. 1 Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ABDOMINAL CARCINOMATOSIS 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA (POLYP) OF COLON DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 weeks 9 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-7, 1957 , to 2-18, 1958 , that I lost saw the deceased olive on 2-18, 1958 , and that death occurred at 3:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE B. J. Plunkett Jr.		ADDRESS (Street, city or town, state) 617 W. Bel Air Ave.	
PHYSICIAN'S NAME (Type) Barry J. Plunkett Jr., M.D.		DATE SIGNED Aberdeen, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/22/58	
22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery		22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Faring		ADDRESS Aberdeen, Md.	
24a. REC'D BY REGISTRAR FEB 24 '58		24b. REGISTRAR'S SIGNATURE W. L. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

Hospital

Physician

Attending

Interment

Place

Address

Age

Sex

Color

Occupation

Education

Religion

Marital Status

Previous Illness

Cause of Death

Signature

Signature of Physician

Signature of Registrar

Witness

Signature of Registrar

Signature

BUREAU V. 8

FEB. 04 1958

RECEIVED

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2045

CERTIFICATE OF DEATH

02046

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harold Chase</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Hanover</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harold Chase Md 24</u> d. STREET ADDRESS <u>318 N. Stokes</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna Virginia Preston</u>		4. DATE OF DEATH Month/Day/Year <u>2/22/58</u> 19 <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/18/1923</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (In years last birthday) <u>34</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Hanover Chase</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Preston</u>		14. MOTHER'S MAIDEN NAME <u>Kida Poplar</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Kida P. Preston</u>		Address <u>318 N. Stokes St. Harold Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA -</u> <u>254X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDITIS -</u> DUE TO (c) <u>TOXIC GOITRE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 HR.</u> <u>10 YRS</u> <u>BIRTH</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>JUNE, 1957</u> , to <u>FEB 22, 1958</u> , that I last saw the deceased alive on <u>FEB 22, 1958</u> , and that death occurred at <u>4 P M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P. Randall Ross</u>		ADDRESS (Street, city or town, state) <u>200 N. Union Ave -</u>	
PHYSICIAN'S NAME (Type) <u>I. RANDALL ROSS</u>		DATE SIGNED <u>Harold Chase, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/25/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Harold Chase Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Conington</u>		24a. REC'D BY REGISTRAR <u>FEB 27 '58</u>	
ADDRESS <u>Harold Chase, Md</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>	

CERTIFICATE OF DEATH

Form 10-58

BUREAU Y. B.

FEB 27 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02047

2046

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> 31	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stimney Road</u>		d. STREET ADDRESS <u>Stimney Road</u>	
3. NAME OF DECEASED (Type or print) <u>Teresso Pratt Reid</u>		4. DATE OF DEATH <u>February 27</u> 19 <u>58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/15/1893</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Amuel Pratt</u>		14. MOTHER'S MAIDEN NAME <u>Ida Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Catherine E Butler - Aberdeen MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CVD disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>B. E. A. Jr.</u> DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/2/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u> ADDRESS <u>Aberdeen MD</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. E. Smith</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as soon as possible, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Handwritten text, mostly illegible due to bleed-through from the reverse side of the page.

BUREAU V. 3

MAR 6 1939

RECEIVED

Handwritten text at the bottom of the page, possibly a signature or date.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02048

2062

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Aberdeen (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #1				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Morgan Last Reid			4. DATE OF DEATH Month February Day 23 Year 19 58				
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Dec. 1893		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman, Salvage Sect U.S. Govt.			10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Reid			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-01-3951		17. INFORMANT Teressa Reid Address R.D. #1, Aberdeen, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute Congestive Heart Failure DUE TO (b) Acute Pulmonary Edema DUE TO (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/6 , 19 53 , to 2/23 , 19 58 , that I last saw the deceased alive on 2/23 , 19 58 , and that death occurred at 10:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 569 Revolution St., Harford, Md. DATE SIGNED 2/24/58							
ACTUAL SIGNATURE George T. Stansbury		PHYSICIAN'S NAME (Type) George T. Stansbury					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/26/58		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Lanning Address Aberdeen, Md.				24a. RECEIVED BY REGISTRAR DATE FEB 27 1958		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR FUNERAL HOME: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2047

CERTIFICATE OF DEATH

Reg. Dist. No. 2049

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 HAVRE DE GRACE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Franklin St				d. STREET ADDRESS 1 FRANKLIN, ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last GUSTAVOUS M. SINCLAIR				4. DATE OF DEATH Month Day Year FEB. 18 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 9, 1874		9. AGE (In years last birthday) yrs. 83	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Boats (WATER)		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SINCLAIR				14. MOTHER'S MAIDEN NAME Louise MASON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Theresa Williams		Address BOURBON, ST HAVRE DE GRACE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-4 , 19 57 , to FEB. 12 , 19 58 , that I last saw the deceased alive on 1-6 , 19 58 , and that death occurred at 10:15 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE GUNTHER D. HIRSCH M.D.				ADDRESS (Street, city or town, state) 421 Congress Ave. HAVRE DE GRACE MD.			
DATE SIGNED FEB 24 58							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB 21 1958		22c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.		22d. LOCATION (City, town, or county) (State) HAVRE DE GRACE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell				ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR FEB 24 58	
				24b. REGISTRAR'S SIGNATURE W. J. Hirsch			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 24 1958

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2063 CERTIFICATE OF DEATH

02050

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		LENGTH OF STAY (in this place) <u>5 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>Rt. # 7</u>			
3. NAME OF DECEASED (Type or Print) <u>Frances</u> (First) <u>Szukielevitz</u> (Middle) <u>Szukielevitz</u> (Last)				4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>3</u> (Year) <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 7, 1893</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Unkown</u>				14. MOTHER'S MAIDEN NAME <u>Unkown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Joseph J. Szukielevitz, Bradshaw, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
174X IMMEDIATE CAUSE (A) <u>Carcinoma of uterus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr. 1, 1956</u> , to <u>Feb. 3, 1958</u> , that I last saw the deceased alive on <u>Feb. 1, 1958</u> , and that death occurred at <u>9:35 P.M.</u> , from the causes and on the date stated above. SIGNATURE <u>William A. Tyson</u> M.D. ADDRESS (Street, city, town, state) <u>Kingsville Md.</u> DATE SIGNED <u>Feb. 3, 1958</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 5, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland. (22)</u>	
24. REC'D BY REGISTRAR <u>Feb 6 '58</u>		REGISTRAR'S SIGNATURE <u>Arthur</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McGowan Jr</u>		ADDRESS <u>Abingdon, Md.</u>	

DECLARATION OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

DATE OF EXAMINATION

PLACE OF EXAMINATION

SIGNATURE OF DECEASED

DATE OF SIGNATURE

PLACE OF SIGNATURE

SIGNATURE OF WITNESS

DATE OF SIGNATURE

PLACE OF SIGNATURE

SIGNATURE OF DECEASED

DATE OF SIGNATURE

PLACE OF SIGNATURE

SIGNATURE OF WITNESS

DATE OF SIGNATURE

BUREAU V. 2

EB 6 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02051

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberteen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. STREET ADDRESS <u>Aberteen Road</u>	
3. NAME OF DECEASED (Type or print) <u>Virginia Gullion Tibbs</u>		4. DATE OF DEATH <u>February 4</u> 19 <u>58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/17/1891</u>
9. AGE (in years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jack Gullion</u>		14. MOTHER'S MAIDEN NAME <u>Lee Turner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213/16/4924</u>	
17. INFORMANT <u>Brother Johnson Box 351 Aberteen #2 Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u> DUE TO (b) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Diabetes mellitus</u> <u>Amputation of right (diabetic gangrene)</u>		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/8/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Darrington Aberteen Md.</u>		24a. REC'D BY REGISTRAR <u>Feb 10 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Feb 10 '58</u>		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as soon as possible, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 10 1958

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02052**

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Hanover b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hanover Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Mills St Port Deposit d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertha M. Webster 4. DATE OF DEATH February 21 1958 5. SEX F 6. COLOR OR RACE C 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH April 25, 1928 9. AGE (in years last birthday) 29 yrs. 10. UNDER 1 YEAR <input type="checkbox"/> 11. UNDER 24 HRS. <input type="checkbox"/>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic 10b. KIND OF BUSINESS OR INDUSTRY Private home 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Smith 14. MOTHER'S MAIDEN NAME Estella Cain		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 214-34-3460 17. INFORMANT Joseph Webster, Port Deposit, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3rd degree burns body 916.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Bottled Gas Exploded		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 3 Hour 1-31 19 58 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street 20f. (City or town) Port Deposit Cecil Md (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald P Palmer M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md. DATE SIGNED 2-2-58		EXAMINER'S NAME (Type) Gerald P Palmer MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL Burial 22b. DATE THEREOF 2-5-1958 22c. NAME OF CEMETERY OR CREMATORY Hosanna 22d. LOCATION (City, town, or county) (State) Darlington, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son ADDRESS Perryville, Md. 24a. REC'D BY REGISTRAR FEB 5 1958 24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as soon as possible, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3.

FEB 3 1953

RECEIVED

2050

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i> 24	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>315 So. Stokes Street</i>		d. STREET ADDRESS <i>315 So. Stokes Street</i>	
3. NAME OF DECEASED (Type or print) First <i>RUFUS</i> Middle <i>E.</i> Last <i>WING</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>4</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 21, 1883</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months <i>4</i> Days <i>14</i>	IF UNDER 24 HRS. Hours <i>4</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>St. Dept. City</i>	11. BIRTHPLACE (State or foreign country) <i>Harford County, Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>		13. FATHER'S NAME <i>Abe Wing</i>	
14. MOTHER'S MAIDEN NAME <i>Maria Gallaway</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>214-12-2463</i>		17. INFORMANT Address <i>Mrs. Verlie Wing - 315 So. Stokes St Harre de Grace, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heartdisease</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/15</i> , 19 <i>57</i> , to <i>2/4</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>2/3</i> , 19 <i>58</i> , and that death occurred at <i>1:45 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>George T. Stansbury</i> M.D. <i>569 Revolution St., Harre de Grace, Md. 2/6/58</i> PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>2/7/58</i>	<i>St James Cemetery</i>	<i>Harre de Grace, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Elmer E. Bullenk - Harre de Grace</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 10 58</i>	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM BOYD

BUREAU V. S.

FEB 10 1958

RECEIVED

2064

CERTIFICATE OF DEATH

02054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARDIFF				c. LENGTH OF STAY IN 1b 13 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) GEORGE ELLSWORTH YOUNG				4. DATE OF DEATH FEB. 25, 1958			
5. SEX M		6. COLOR OR RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 18, 1890	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) YORK CO., PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARETAKER				10b. KIND OF BUSINESS OR INDUSTRY CEMETERY			
13. FATHER'S NAME ADAM YOUNG				14. MOTHER'S MAIDEN NAME EMMA STEVENSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 166-12-4883			
17. INFORMANT MARY E. YOUNG				Address CARDIFF, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Hypertensive C-VD Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 yrs (c)						INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute prostatitis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 2, 1958 to Feb 24, 1958 , that I last saw the deceased alive on Feb 24, 1958 , and that death occurred at 6:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Ralph Henky MD				ADDRESS (Street, city or town, state) Churchville Md DATE SIGNED Feb 26			
PHYSICIAN'S NAME (Type) J. Ralph Henky MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-28-58		22c. NAME OF CEMETERY OR CREMATORY HENDERSON HILL		22d. LOCATION (City, town, or county) (State) BEAIR, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harbison, Delta, Pa. ADDRESS				24a. REC'D BY REGISTRAR DATE FEB 27 '58		24b. REGISTRAR'S SIGNATURE Chas. Beach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE TO BE FILLED BY THE DEATH REGISTRAR		PLACE TO BE FILLED BY THE DEATH REGISTRAR	
1. NAME OF DECEASED		2. SEX	
3. AGE		4. RACE	
5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF BIRTH		8. PLACE OF DEATH	
9. OCCUPATION		10. CAUSE OF DEATH	
11. MANNER OF DEATH		12. SIGNATURE OF DEATH REGISTRAR	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER	
15. SIGNATURE OF MINISTER OF THE GOSPEL		16. SIGNATURE OF CHURCH CLERK	
17. SIGNATURE OF BURIAL CLERK		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF CEMETERY CLERK		20. SIGNATURE OF INTERMENT CLERK	
21. SIGNATURE OF HEALTH DEPARTMENT		22. SIGNATURE OF COUNTY CLERK	
23. SIGNATURE OF CITY CLERK		24. SIGNATURE OF STATE CLERK	
25. SIGNATURE OF DEATH REGISTRAR		26. SIGNATURE OF DEATH REGISTRAR	
27. SIGNATURE OF DEATH REGISTRAR		28. SIGNATURE OF DEATH REGISTRAR	
29. SIGNATURE OF DEATH REGISTRAR		30. SIGNATURE OF DEATH REGISTRAR	
31. SIGNATURE OF DEATH REGISTRAR		32. SIGNATURE OF DEATH REGISTRAR	
33. SIGNATURE OF DEATH REGISTRAR		34. SIGNATURE OF DEATH REGISTRAR	
35. SIGNATURE OF DEATH REGISTRAR		36. SIGNATURE OF DEATH REGISTRAR	
37. SIGNATURE OF DEATH REGISTRAR		38. SIGNATURE OF DEATH REGISTRAR	
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95. SIGNATURE OF DEATH REGISTRAR		96. SIGNATURE OF DEATH REGISTRAR	
97. SIGNATURE OF DEATH REGISTRAR		98. SIGNATURE OF DEATH REGISTRAR	
99. SIGNATURE OF DEATH REGISTRAR		100. SIGNATURE OF DEATH REGISTRAR	

BUREAU V. 5

FEB 27 1959

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